



### Patient Questionnaire re COVID-19

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Questions

1. Have you got a cough, high temperature or shortness of breath now, or have had any time in the past week? Yes / No
2. Have you lost your sense of taste or smell? Yes / No
3. Does anybody in your household have a cough, high temperature, shortness of breath, or have a confirmed, positive test or COVID-19 diagnosis? Yes / No

If so, who? \_\_\_\_\_

#### Patient or person completing the form

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

***If any answers are "YES" to the questions above, please do NOT proceed with any treatment, and as necessary, refer to the Clinical Lead or Manager.***